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## Higher professional education

Smith *et al* (April *Journal*)<sup>1</sup> are to be congratulated on their admirable survey on beliefs about higher professional education (HPE).

However, they are mistaken when they say that the Wessex HPE courses have been discontinued. They are very much alive and I am facilitating a new group at present. Further information on these courses is available from the Wessex Faculty office.

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## Competency model for general practice

We wish to commend Patterson *et al* (March *Journal*)<sup>1</sup> on their endeavour to describe a competency model for general practice. We fully support their view that it is important to be able to describe not only what we do but also what our patients want us to do. We are also gratified that they have provided further support for the validity of the component consultation competences contained within the Leicester assessment package which, although reported in the *Journal* six years ago,<sup>2</sup> was not cited in this paper.

We are dismayed that the authors' literature review and your referees failed to identify this omission. Furthermore, the findings of a large corpus of education

research over the past 20 years demonstrating that pencil and paper tests are poorly predictive of actual clinical performance were also overlooked. We would particularly take issue with the authors' assertion that 'psychometric tests ... [of] problem solving ... have good predictive validity' for clinical problem solving ability. Van der Vleuten<sup>3</sup> and Norman and Regehr<sup>4</sup> summarise the powerful evidence against this assertion.

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## *Chlamydia* screening in primary care

The issue of screening for *Chlamydia trachomatis* in primary care is an important and topical subject. In their report of a survey of knowledge and practice around

*Chlamydia* in Glasgow, Kinn *et al* (March *Journal*)<sup>1</sup> raise some important issues.

Their results confirm what has previously been suggested: a selective, opportunistic screening programme based on active involvement of already overburdened primary health care teams is unlikely to succeed.<sup>2</sup> Even if such an approach was coupled with a substantial investment in education and extra resources, we are sceptical about its probable success. A research team of committed, enthusiastic, and extremely knowledgeable primary care sexual health specialists managed to reach less than 30% of their target population in a recent London study using this model.<sup>3</sup> Adequacy of sampling is a relatively simple issue to address through training; poor coverage and consequent negligible population impact is a more fundamental problem. This is compounded by the fact that many studies in this area seem not to have considered the issue of screening young men.<sup>1-3</sup>

The evidence for the effectiveness of selective screening confined to women is not as strong as Kinn *et al* suggest. Methodological problems in the study they cite were highlighted in subsequent correspondence to *The New England Journal of Medicine*.<sup>4</sup> In addition, the system of primary care within which this study was undertaken is very different to the National Health Service.

The Department of Health seems to be more open-minded on all these questions than the original report to the Chief Medical Officer might have led them to be. In parallel with the pilot studies of the opportunistic, selective approach, the *Chlamydia* Screening Studies Group has been commissioned to look at some of the wider issues.<sup>5</sup> A small study from Bristol has shown systematic, register-based screening of men and women involving home-mailed, self-collected samples to be feasible.<sup>6</sup> A new study will investigate the effectiveness of this approach, which has the further advantage of minimal extra workload for primary care, among 18 000 men and women in the Midlands and south-west of England. This study will also address the other issues highlighted

by Kinn *et al* of the most appropriate samples and tests and the most effective means of partner notification. It will also explore an important area they did not mention: the patients' perceptions of the costs and benefits of being screened.

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The report by Kinn *et al* (*March Journal*)<sup>1</sup> makes very interesting reading. The need for population screening for *Chlamydia trachomatis* has been recognised for sometime now. The difficulty with selecting the most cost-effective screening method has been a considerable drawback.

Their survey shows that the Department of Health's (DoH's) view that 'the existing educational system for General Practitioners confers adequate competency in *Chlamydia* screening in primary care'<sup>2</sup> may be flawed. There is no doubt that the DoH's check list of those who should be

screened is fairly comprehensive. However, a population report from the United States suggests that no single risk factor or combination of risk factors can identify more than 42% of infections in the population.<sup>3</sup> I am therefore of the opinion that all sexually active females should be screened, rather than the selective policy of screening only the sexually active under-25s or the over-25s who have had more than one partner in the preceding 12 months.

The deadline for testing will only be utopian if those who are expected to deliver the services are ill-equipped to do so. Current GPs' and Practice Nurses' education in this regard must be accepted as inadequate and further training put in place before the full implementation of the guidelines.

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## E-mail consultations

The article by Neville *et al* (*March Journal*)<sup>1</sup> examining practical issues surrounding e-mail consultations highlights an expanding role for consultations at a distance, including telephone consultations, fax, and telemedicine. The expansion in these types of consultation is part of a changing background driven by advances in technology and telecommunications, which have seen almost universal access to the telephone and a rapid expansion in personal computer ownership. Our patients are also consumers living in a 24-hour society and are becoming aware of an increasingly global culture.

We feel that, currently, GPs' attitudes to e-mail consultations are similar to their approach to telephone consultations over 20 years ago. GPs at that time felt that the telephone was a useful tool when they took the initiative but a nuisance when

patients used it as a means of consulting them.<sup>2</sup> In the interim, patients found the telephone convenient for making appointments, asking for therapeutic advice, enquiring about test results, requesting a home visit or obtaining repeat medication.<sup>3</sup> It is in this latter area that e-mail is finding its first use in contemporary practice. E-mail consultations have the attraction of being non-time specific, of leaving a better 'paper trail' than telephone consultations (as illustrated by Neville *et al*), and of offering links to other medical sources of information on the Internet. GPs are worried about being overwhelmed by further uncontrolled patient demand for advice and information.

Telemedicine may also become an important part of this distance consulting process. Globally, it has proved to be useful where there are barriers of time and distance.<sup>4</sup> In the primary care setting, community-based care may be enhanced with convenience for patients and the potential for skills transfer and medical education.<sup>5</sup>

Neville *et al* are right to highlight medico-legal concerns about consulting at a distance. The Medical Defence Union has issued a warning to GPs who advise patients by e-mail, suggesting that they should ensure the communication is secure and follow-up individual cases.<sup>6</sup> This advice is echoed in guidelines published by the American Medical Information Association Internet Working Group.<sup>7</sup> Their guidelines addressed two interrelated aspects: how to have effective interaction between the clinician and the patient and the observance of 'medico-legal prudence'. The guidelines examined e-mail between patient and provider where there was an existing 'contractual relationship' (doctor-patient relationship) in which the health care provider has taken on an explicit measure of responsibility for the client's care. While based in the context of American medical practice, where 1% to 2% of physicians offer an e-mail access to their services, these guidelines could form the basis of guidelines for consulting at a distance in British general practice. We feel that such guidelines could be important and useful and allow a safe and effective expansion of these forms of consultation.

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Overcoming the constraints to becoming paperless

Waring's article (January *Journal*)<sup>1</sup> describes a natural and essentially uncoordinated move towards paperless working in general practice. The report presents the constraints identified by practice managers and indicates possible solutions.

We have deliberated this issue within our primary care research group<sup>2</sup> through discussion groups<sup>3,4</sup> and offer a complementary but broader perspective on the constraints (Table 1). We also present possible solutions and timescales that should be considered by practices wishing to migrate towards becoming paperless prac-

tices. Though by no means an exhaustive list, we hope that it is informative to practices considering embarking on a venture to becoming paperless.

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Table 1. Overcoming the constraints to becoming paperless.

Constraint	Solution	Timescale/comment
No time to keep paper and computer records simultaneously.	Unrealistic to do both — if newly computerised, progressively phase out the use of notes as indicated.	Make sure repeat prescribing is accurate in the first year Record key preventive and diagnostic data (year two); Stop written records.
Unable to find key clinical data in electronic records.	Training, especially in the use of clinical codes. <sup>5</sup> Join a data quality group and get feedback; e.g. CHDGP <sup>6</sup> to raise data quality.	An on-going commitment.
Lack of access to long-term written records.	Phase-in shift to computer records. Meanwhile add one key piece of summary data to the computer record each consultation. Make sure records can be 'fast-tracked' to consulting rooms if needed.	Stop providing notes for appointments booked on the day for three months. Stop providing written records for patients booking new appointments (6 months). Stop providing written records.
Lack of access to pathology and X-ray results.	Join a pathology — link projects to get automatically delivered electronic results. Scan results/reports that can't be delivered electronically. Direct manual data entry.	Electronic pathology should be available for more than one year before removing access to the written record.
Lack of access to hospital letters and reports.	Scan the text into the patients notes. E-mail from consultant to GP (subject to correct security in place). Scan letters as images. Manual coded summaries.	Recommended to have at least one year's letters electronically archived before moving to noteless practice.
Finding clinical measurement records on paper (e.g. ECG, spirometry etc).	Invest in electronic clinical measurement software as part of the migration to paperless practice.	Phase in introduction of: spirometry, ECG, INR software etc. Make integral, if possible, with practice clinical system.
How to access clinical knowledge and know-how.	Connect to a primary care information portal (NeLH-PC) via NHSnet. <sup>7</sup> Provide in-practice electronic library.	Access to information can provide early benefit, though other steps are not dependent on it.
Constraints to paperless administration		
Finding electronically recorded information.	Provide in-practice electronic library. Circulation of documents as e-mail.	Simultaneous sending of information to whole practice team is efficient.
Communication by paper.	Use e-mail, electronic diaries and scheduling software. Use e-commerce, bank-line and electronic accounts.	Phase introduction.

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7. NeLH-PC (Primary Care National Electronic Library for Health). URL: <http://www.nelh-pc.nhs.uk>

## Prescribing costs

Avery *et al* (February *Journal*)<sup>1</sup> report that GPs working in practices with either high or low prescribing costs had different views on a number of statements concerning substitution with comparable but cheaper drugs. The three therapeutic areas were SSRIs, nitrates, and modified release NSAIDs and were chosen from the Audit Commission report.<sup>2</sup> This 1994 report identified savings of over £425 million for England and Wales if all GPs were to prescribe in the same way as 50 'good practices'. Two of the themes chosen by Avery *et al* (use of isosorbide dinitrate rather than mononitrate and using fewer of the modified release NSAIDs) contributed a potential saving of only £5.5 million (1.3%) to the overall total of £425 million. Clearly, the use of SSRIs as firstline treatments for depression would influence, to some degree, the cost of prescribing. However, treatments for depression account for only about 6% of total GP prescribing costs.<sup>3</sup>

It may well be that if the practices categorised as high-cost had prescribed in these three areas in a similar manner to an average Trent practice they would still have been classed as high-cost, simply because the use of SSRIs, nitrates, and modified release NSAIDs contributes little to practices' overall costs. Hence, we must not assume that high-cost prescribers are high-cost simply because of their attitude towards the three therapeutic substitutions

tested in this study. Indeed, non-fundholders have been shown to use SSRIs as a percentage of all antidepressants at a rate similar to cost-conscious fundholders.

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## Primary care groups and research

Thomas *et al* (February *Journal*)<sup>1</sup> are correct in asserting that collaboration between primary care groups (PCGs) and primary care research networks offers an exciting opportunity for the development of multidisciplinary, locally owned, and locally relevant research. They stress that the process will take time to bear fruit. One of the reasons for this, and one of the barriers to PCGs effectively supporting research and development (R&D), is the present culture of primary care.

In a survey of research capacity in primary care, Campbell *et al* (December *Journal*)<sup>2</sup> identified a lack of skills among primary care practitioners, which seemed to be compounded by inadequate training opportunities and an absence of protected time. This reflects a wider problem in primary care, in which time spent away from the ever-widening 'coal face' of clinical care is both difficult to achieve and undervalued. As a result, reflective practice, personal development, and practice development are consigned to time outside the normal working day. In order for primary care to develop and flourish, these activities need to be part of the normal working day for all GPs. This creates a challenge for PCGs but one that they are well placed to meet.

Primary care groups are required to develop primary care. One element of this process should be the creation of protected time in the working day for practices and for individuals in those practices. This could be done, for example, by the use of salaried GPs to relieve the clinical workload, by the PCG providing a phlebotomy service to release nursing time, or by administrative support for audit work. A particularly innovative scheme has just started in Chester, where the PCG funds an extension of the out-of-hours co-operative to create an educational half-day each month for the whole of the city.

Research and development is a vital element of clinical governance and evidence-based medicine. In order to support the clinical governance agenda, research and development needs to become more 'mainstream'. This means not only more primary care clinicians doing research but, perhaps more importantly, an increased understanding among all primary care clinicians about the interpretation and application of research findings.

If PCGs can aim to facilitate a culture change that provides effective protected time for clinicians, while working closely with their local research network, this would be a powerful combination. It will facilitate not only locally owned and locally relevant R&D but also raise the standard of primary care as a whole.

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## Correction

There were several errors in a letter from Michael D'Souza *et al* entitled 'Dermaclinic: preliminary triage by GP specialoids?', which appeared in the March issue of the *Journal* (page 238). In the first paragraph, 'fermatology' should read 'dermatology'; in the footnote, 'www.mdintranet.nhsweb.nhs.uk' should read 'www.mdintranet.nhsweb.nhs.uk'; and, also in the footnote, 'www.agora.co.uk' should read 'www.agorahealth.co.uk'. We apologise to the authors for the errors and for any confusion they may have caused.